The Effects of Social Stigma on Mental Health Treatment and Access for United States Military Veterans: A Focus on Indiana

An Honors Thesis (HONR 499)

by

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April 2019

Expected Date of Graduation

May 2020

Abstract

Mental health issues plague all of society but are especially prevalent within the military as the high stress job requirements and masculine culture only making these issues worse. Mental health issues have gone by many names, from war neurosis, to shellshock, and finally to post-traumatic stress disorder, but the key is that it has existed in some form or another in the military for over a century. The United States Veterans Administration has made it one of their key initiatives to combat these issues; however, they are falling short. Through the exploration of the history behind the issue and in-depth analysis of treatment options for mental health issues, not only is awareness brought to the issue, but the reader is able to extrapolate and draw conclusions in a variety of areas. These treatments could be applied to civilian sectors and populations, or thought to apply to a specific region in the United States. Within the paper, Indiana is used in this way, not only to help provide an example of this process, but also as a way to relate the information to a real world example. From all of this information, suggestions as to how to improve care and access for veterans can be drawn.

Acknowledgements

I would like to thank my advisor Dr. Alexander Kaufman for his continued guidance and working with me throughout this long process. His continued direction as I ran into roadblocks during the process was invaluable for allowing me to complete the project on time. The ideas and questions he had about my paper allowed the project to become what it is.

I would also like to thank all my friends and family for putting up with months of me constantly talking about this project, dealing with me as I stressed about getting sections done, and being a sounding board for different ideas I had.

Lastly, I would like to thank my mom and grandmother, for also being sounding boards, as well as always being willing to read and edit sections as I finished them.

Process Analysis

The idea to explore the effects of social stigma on the access and treatment for healthcare began developing during my psychiatric nursing class during the Fall of 2018. I was able to have my clinical experience take place at the VA hospital in Marion, Indiana, where I encountered both acute and chronic psychiatric patients, all of whom were military veterans. I myself am from Fort Wayne, Indiana, and it appalled me to hear of veterans being sent from the VA hospitals in Fort Wayne, Indianapolis, and from all over the state of Indiana to Marion because it was the only VA hospital in the state to offer any inpatient psychiatric beds. This situation really sparked my interest in not only understanding why Marion was the only VA hospital within the state to have inpatient beds but also what else could be done in my hometown of Fort Wayne to better treat these patients closer to home, where they would be better able to receive social support.

Through this process, I have most definitely learned my limits as a student, writer, and researcher. This semester, on top of attending nursing school, I worked two part-time jobs in addition to completing this thesis. Looking back, I feel like all of this together had a negative impact on my writing for this thesis in the short term. The beginning of the semester was front-loaded with not only work for the thesis but also clinical work for nursing. This forced me to rush through writing sections of the thesis and not dedicate as much time as I would have liked to really critically think through what I was write or plan as I normally would. It also forced me to work on this project in bigger pieces over a shorter time span, rather than in smaller bits over longer periods of time. Ultimately, I was able to go through and get my writing up to a level that I feel I would normally write at and be happy with the content I was producing.

Aside from not feeling I had adequate time to devote to the project like I wanted to, another problem I had to overcome throughout this process was my anxiety of talking on the phone. No matter what it is I have to conduct over the phone, I always experience a great deal of anxiety, and having to do it for a project of this magnitude only increased this. Fortunately for me, early on I realized I simply did not know enough information about the subject or specifically about the VA in Fort Wayne to formulate questions to ask of various leaders of agencies dealing with veterans in the area and this provided a convenient excuse for me to put these phone calls off. However, it came to the point that I was no longer able to justify not picking up the phone with lack of information and I bit the bullet and made the calls. This lead to perhaps my greatest frustration with the entire process, having to rely on others to complete my side of the project.

Although I overcame my anxiety of picking up the phone to call others, this itself was not enough to make the interviews actually happen. I not only ran into trouble actually getting ahold of people, I also encountered one agency that just never returning calls, and another one stopped returning calls in the middle of phone tag. But I also had one person just never finish getting back to me. A family emergency caused this interviewee to be unavailable for nearly two weeks, which put a great deal of stress on me in getting my thesis done. I had reached a point where I had nearly all the sections written I could without the interview data, and I was stuck waiting on others before I could move on in the writing process. In the end, this person never got back to me with answers to the questions, forcing me to refocus my thesis.

The biggest issue I had throughout the project was coming to so late a point into the project and not able to have any interview data, I was left with no options other than to change the scope and focus of my thesis itself. I had to make the aim of the paper on exploring the

problem of mental health issues in the military and doing a literature review of the current treatment approach, with a minor section on how this problem impacts Fort Wayne, instead of a case study about this issue in Fort Wayne. While this drastically changed the overall goal of my thesis, it still has tremendous value and impact for me and anyone who reads it. It raises awareness about the history of mental illness in the military, and it gives context for persons encountering a veteran suffering from one of these diseases, thus allowing them to have more empathy and compassion. This paper explores the wide variety of treatments, both successful and not, in the hopes of sparking new ideas in other avenues of treatment or allowing a practitioner to have a better understanding of the treatment themselves in order that they can better explain it to a patient. Lastly, the conclusion section extrapolates on what I perceived the problem to be and my reaction to the situation in Fort Wayne could not only allow further research to be done in a case study fashion on Fort Wayne but also allow someone else to take my ideas and apply it to a different location.

In the future, I would definitely be wearier to do anything involving interviews. I think that my desire to be self-sufficient and not need to rely on other people to complete work was only heightened by this experience. However, I also now see after having to change my paper focus the true value of having first-hand interview data as support. While the literature gives lots of good information, great weight and true understanding can come from interviewing people with first-hand knowledge and experience. All this said, while I would be weary to do research involving interviews, I think I would definitely do it because I can really see the true value in this type of data.

Introduction

Nearly 25% of active duty United States military service members show signs of a mental health condition. The rate of post-traumatic stress disorder among military members is 15 times higher than the prevalence among civilians. Depression is five times higher among military members than in civilians (Veterans & Active, 2019). Among Iraq and Afghanistan military veterans alone, 30% "have a mental health condition requiring treatment" and less than 50% in need of mental health services "receive any mental health treatment" (Veterans, 2019).

These are just a few of an overwhelming plethora of statistics highlighting the wide-reaching effects of mental health issues affecting current and former US military personnel. Lack of affordable or feasible geographic access to mental health services, perceived or real barriers to treatment, and perceived and real stigma towards mental illness are all factors in the current state of treatment and access for mental health services. These factors are only complicated when the culture of the military and careers within it are put in jeopardy when service members seek out services for mental health issues they are having. They face stigma from within the military from both peers and commanding officers who hold the view that "real men" do not have mental issues and those that do are cowards. Society only reinforces this culture by associating any person in uniform with a macho, manly persona.

Besides society and culture limiting the personal choice to seek treatment, there are also physical factors outside of personal control that also need to be factored in. The Veterans Association only has so much funding, and as such, it has to pick and choose where this money can be allocated. A prime example of this can be seen in the state of Indiana, where there is only one VA hospital that has any inpatient beds for acute or chronic psychiatric conditions. The VA also limits reimbursement or coverage for mental health services outside of its own services.

These are all factors that are outside of a veterans' control and negatively impact their ability to get treatment should they chose to seek it out.

Historically, in both the publics' and within the military's eye, mental health has become a more talked about and more acceptable issue. From World War I all the way through Vietnam, the issue of mental health was largely ignored or stigmatized to the point of actively shunning or discharging soldiers suffering from them. Even after the acceptance of post-traumatic stress disorder as a legitimate medical diagnosis following the Vietnam War, the past decades of stigmatization has made forward progress around the issue slow going. Stigma still exists; the culture within the military still looks down upon anyone with these issues, and despite being a primary goal of the Veterans Administration to combat mental health for over a decade, yet little positive impact has been made.

Current treatment approaches such as various psychotherapies, medications, and extended treatment programs have all been proven effective; however, the implementation and reach of them has been a major cause in lack of progress in combating mental illness. Perhaps the biggest issues are the lack of organization among professionals and the numerous steps it takes for a veteran to actually receive treatment. These combined with the barriers social stigma creates makes successful treatment nearly impossible. A population-based approach, using the primary care physician to initiate all care specialties, both medical and psychiatric, is currently limited in implementation but provides the greatest hope for making a meaningful impact for the veterans suffering from mental health issues.

History

The atrocities of war are far reaching, affecting citizens and soldiers alike. World War I saw massive destruction across Europe, devastating the land and people. In order to facilitate

combat effectiveness, leaders within the United States military began focusing on screening new recruits before being deployed in the hopes of decreasing the high incidence of nervous breakdowns. This drastic change in thought meant that involving psychiatrists would not hinder operations but in fact enhance them.

The prevailing theory, put forth by psychiatrist Thomas Salmon, was that the nervous breakdowns occurring in the trenches were related to the individuals own characteristic instability. According to Oak and Pols (2007), Salmon proposed to use screenings to exclude "insane, feeble-minded, psychopathic, and neuropathic individuals" (Oak & Pols, 2007, p. 2133). Because this theory was not accepted or implemented until later in the war, the overall effectiveness could not be confirmed nor denied; however, the common consensus among psychiatrists and military officials was that too many breakdowns occurred. Following the acceptance and inclusion of psychiatrists aiding the war effort during World War I, World War II saw similar integration of the profession, but this time, from the outset of the war.

Building on Salmon's work, psychoanalyst Harry Stack Sullivan developed a new theory to apply towards the screening process for enlisters and recruits in the hopes of further reducing the number of breakdowns when in the war theatre. Oak and Pols (2007) presented that Sullivan's theories, in addition to those developed by Salmon, sought to exclude from service, that those with "neurosis or maladjustment" (p. 2133) should be disqualified as well. It was his belief that those who were unable to adjust in society would not be able to deal with life in the military or the experiences of being in war. During the time the United States was sending troops into combat during World War II, the screening criteria set forth by Sullivan "excluded 12% of 15 million men" (Oak & Pols, 2007, p. 2133).

The most concerning aspect of these breakdowns, referred to as "war neurosis" (Garske, 2011, p. 31), was when they occurred on the frontlines, an unfortunately common occurrence. The solution the military implemented was forward psychiatry, suggested in 1943 by psychiatrists Roy Grinker and William Menninger, which called for treatment as near to the frontlines as possible. Treatment included using sodium pentothal to induce a dream state and allow the soldier to therapeutically re-experience the trauma in addition to having "rest, good food, and hot showers" (Oak & Pols, 2007, p.2135). Perhaps the most important lesson drawn from the evaluation of this new concept of forward psychiatry was not that it was widely regarded as a failure for enhancing combat effectiveness, but that it shifted the attention "from problems of the abnormal mind" to "problems of the normal mind in abnormal times" (Oak & Pols, 2007, p.2135). The accepted viewpoint was now looking towards the situation and environment being the problem rather than the individual. With this shift in thought in mind, the approach towards psychiatric issues in Korea and Vietnam focused on enhancing the effectiveness of forward psychiatry rather than starting from scratch to develop a new method of treatment.

The fast-changing front lines and wide battlefields forced officials to determinedly push forward psychiatry during the Korean War. During this war, the strategy was perfected and "more than 80% of neuropsychiatric victims" (Oak & Pols, 2007, p.2136) successfully returned back to the frontlines. Due to the perfection of the process for the fast-paced and ever-evolving nature of the war in Korea, the strategy was well suited for the similar situation when the Vietnam War began. Based on previous recommendations from psychologists since World War II, all soldiers not only had access to psychiatrists, but also tours were now "limited to 1 year and frequent periods of rest and relaxation" (Oak & Pols, 2007, p.2136). These strategies helped to

reduce the number of soldiers having to leave the combat theatre to less than 5% of all the medical and mental health cases.

Starting with the Vietnam War and moving forward, teams dedicated to mental health became an instrumental part to all fighting forces in the United States military. The new thought was that because environmental and psychological stressors of war were the cause of psychiatric issues, each individual soldier represented a potential psychiatric causality. With this idea in mind, teams were integrated at all levels and in all areas of the military. These team members were responsible for "prevention, triage, and short-term treatment" (Oak & Pols, 2007, p.2136) while also providing services such as education, briefings, conducting surveys, and reintegration counseling to the unit and to home.

The biggest developments into psychiatric care following the Vietnam War were critical incident stress debriefing, the inclusion of post-traumatic stress disorder (PTSD) as a diagnosable disease, and the belief that recovering from a breakdown and returning to battle would have no long-term consequences after the war, leading psychiatric problems after the conclusion of the war to be attributed to preexisting conditions rather than the war experience. Engel, Hyams, & Scott (2006) explain critical incident stress debriefing, widely considered to be the best treatment method during this time, involves going over the traumatic experience as soon as possible to identify immediate concerns, provide an outlet for grief and anger, and providing closure about the event (Engel, Hyams, & Scott, 2006, p. 710). Perhaps the biggest of these developments was the inclusion of PTSD into the *Diagnostic and Statistical Manual for Mental Disorders* (DSM) in third version in 1980. The acceptance into official diagnosis lent PTSD credit as a real issue, while somewhat reducing the stigma surrounding the disorder, did more to raise awareness to an issue long ignored by the military. Despite giving little attention to the veterans themselves

suffering from mental illness following this particular war, the outcomes listed above paved the way for treatment of veterans returning from future conflicts.

Following the withdrawal of US troops from Vietnam, the United States enjoyed nearly a decade of reprieve from mass deployment and engagement in a combat theatre; this changed upon the Iraqi Army invading Kuwait in August of 1990. The US deployed troops to the area less than a week afterwards in conjunction with a United Nations Coalition Force that ultimately consisted of 40 nations. Even though this conflict only lasted some six months, it still severely affected the mental health of the individuals stationed there. Upon returning to the United States, many soldiers began to report a variety of non-specific symptoms such as "fatigue, headaches, joint pains, skin rash, shortness of breath, sleep disturbances, difficulty concentrating, depression and forgetfulness" (Engel et al., 2006, p.707). Because of the exposure these soldiers experienced to various environmental hazards, such as depleted uranium, burning oil, and pesticides, it was common practice to simply attribute the collection of symptoms, which came to signify a new illness called Gulf War Syndrome, to exposure to this variety of hazards. The prevalence of this new disease overshadowed all other issues, especially PTSD, and caused the majority of public and official attention to be diverted towards Gulf War Syndrome; as a result, they largely ignored other issues (Oak & Pols, 2007, p.2138).

Besides public focus on Gulf War Syndrome, the military culture of the time also limited the number of soldiers reporting or seeking treatment for psychiatric issues. It was a pervasive belief within the military at this time that "displaying psychiatric symptoms indicated weakness of character or cowardice" (Oak & Pols, 2007, p.2138). In addition to the underutilization of services, the massive amounts of research money spent on finding the cause of Gulf War Syndrome to no avail caused a shift in focus towards medical treatment in general for veterans

after their service. Instead of attempting to find specific causes for specific diseases, the focus was now implementing a new treatment model, population-based care, which proposed to have all care originate in the primary care setting as opposed to specialist medical intervention (Oak & Pols, 2007, p.2139). Population-based care has become the basis for all treatment approaches and initiatives, as it has been the foundation for all approaches to healthcare for veterans since the mid-1990s.

Like the time period between Vietnam and the Gulf War, the United States enjoyed a similar time period between the Gulf War and its next major conflict, the wars in Iraq (Operation Iraqi Freedom, OIF) and Afghanistan (Operation Enduring Freedom, OEF) following the terrorist attacks on September 11, 2001. This still ongoing war brought a whole new environment to fight in. The new environment, the urban settings, and the need to work with the populace to help rebuild the country caused military fighting and relations tactics to be rethought and general frustrations to develop. The fighting quickly shifted from house-to-house and retaking city after city towards maintaining control, fighting off small attacks by small groups of insurgents, and lots of working with locals on repairing damage. It was not uncommon to go to the same village three, four, or five times to clear out a group of insurgents only to have another group set up as soon as the US military vacated. The locals also were intimidated into cooperating with the insurgents through threats of violence, often misleading US troops or just flat-out refusing to help. Improvised explosive devices (IEDs) also became common place in this conflict as the urban environment provided many hiding places and the continual return of US military to certain locations made IEDs a devastatingly effective weapon of not only physical harm but psychological terror. All these variables factor in to why "over one third of all OEF/OIF veterans have a mental health condition" (Keane, Marx, & Sloan, 2011, p.504).

The predominant mental health issue continuing to be seen from OEF/OIF is PTSD, the primary stimulus of this being experiencing a traumatic event. Killing combatants, soldiers having their lives threatened, observing or being involved in handling remains, exposure to death, and living in a war zone under constant threat of injury (Garske, 2011, p.32) are all examples of traumatic events soldiers faced during this conflict. Dr. Charles Marmar (2009), the Associate Chief of Staff for Mental Health and director of the PTSD Research Program with the San Francisco VA Medical Center, lays out the key features of PTSD as "re-experiencing, numbing and avoidant symptoms, hyperarousal in social situations, and an impact on daily functioning" (Marmar, 2009, p.493). It is important to note that these signs and symptoms develop after exposure to an extreme stressor because the manifestations vary so widely from individual to individual (Garske, 2011, p.33). Recognizing the growing problem and incidence of PTSD among OEF/OIF veterans, in 2004, the VA developed a Mental Health Strategic Plan (MHSP) with the goal of

> reducing the burden of mental illness by reducing stigma; promoting recovery; ensuring equal access and reducing variability of care; providing culturally competent care to veterans of all ages, races, ethnic groups and genders; being veteran and family centered; ensuring collaborative care models are used in primary-care team structures; and employing evidence-based population approaches (Keane et. al., 2011, p. 504).

This plan has shaped the past decade of treatment, but it still has many shortcomings. Veterans have fallen through the gaps, wait times and quality of care have declined, and the prevalence of PTSD among veterans has increased. The issue of mental health and PTSD among veterans needs to be reexamined and going forward, a new plan of action needs to be implemented.

The Problem - Stigma Towards Mental Illness

One of the major problems plaguing the military in terms of the treatment of mental illness is the pervasiveness of stigma attached to the topic. Not only is the general culture within the military to not show cowardice through the displaying of psychiatric symptoms, but social stigma also impacts soldiers suffering from these issues as well. Britt, Castro, and Greene-Shortridge (2007) define stigma as a "negative and erroneous attitude about a person" or a "prejudice or negative stereotype" (p. 157) which takes on many manifestations in cultural, public and self. Together, these manifestations create numerous barriers towards accessing or even seeking mental health treatment for veterans.

Within the military, the accepted culture is to be masculine and tough; admitting to or seeking help for mental health issues directly contradicts this. As such, seeking help would cause that individual to be seen as cowardly. It could cause some distancing or isolation from others because they do not want to associate with those who do have a mental illness. Furthermore, the individual might be blamed for the problems they are dealing with and be considered weak for not being able to deal with the issue on their own. Soldiers expressed more discomfort with discussing psychological problems as opposed to medical problems and those that did report psychological problems were twice as likely to report a fear of stigmatization as those reporting medical problems. The macho culture prevalent in the military causes a negative view towards mental illness, a stigma that pervades all levels of command and branches of the military (Britt et al., 2007, p.157).

Public, otherwise known as social, stigma is the "reaction of the general public toward people with mental illness" (Britt, et al., 2007, p.158). Dr. Thomas Britt of Clemson University's Psychology Department, in the journal *Military Medicine*, lays out the three main ways society views any individual suffering from mental illness. First, society views these individuals as

irresponsible and unable to care for themselves. A common negative association that occurs is between mental illness and alcohol or drug dependence, which increases the belief that the individual is responsible for their own problems. Second, society sees those with mental illness as needing to be "feared and excluded." This leads to isolation and exclusion, as well as internalization, causing the individuals to believe they deserved to be feared and ostracized. Lastly, society tends to treat those suffering a mental illness as children, which goes along with society seeing them as unable to care for themselves. Society's views reinforce these negative concepts within the individual, which leads to the concept of self-stigma, and makes the mental illness internalized and more deeply ingrained into an individual's psyche (Britt, et al., 2007, p.158).

The internalization of society's stigma causes an individual to internalize the negative thoughts and lower their sense of self-esteem. Not only is lower self-esteem an issue, but this also negatively impacts the motivation to seek psychological treatment. Internalizing society's views has a negative cyclical effect on the mental health of individuals, and they have a greater sense of responsibility and shame for their illness, provoking more negative societal views, which only further stimulates the cycle.

This self-stigma plays greatly into the real and perceived barriers that individuals face when seeking treatment. Perhaps the biggest barrier that soldiers face is the effect it could have on their career if others learned that they were suffering from or seeking treatment. They would be ostracized and possibly lose security clearances or chances for promotion. Another issue these veterans face is not trusting the medical professionals within the military to keep their issues private and not knowing where to physically go to receive the services. A common practice to try to circumvent these barriers is to go to a civilian psychiatrist, but that brings about a whole other

host of issues such as transportation and money to attend these sessions. Stigma has a snowball effect on an individual suffering from mental illness. Society sees them as different, the individual internalizes this, and the cycle repeats. To help these individuals get better, this cycle needs to be stopped, the barriers to treatment rescinded, and most importantly, the stigma society holds to be changed.

The VA in Fort Wayne, Indiana:

The VA Medical Center in Fort Wayne, Indiana, is a part of a larger network of hospitals in the region that make up the VA Northern Indiana Health Care System, which serves all of the state of Indiana. According to the U.S. Department of Veterans Affairs website, this collection of both VA hospitals and clinics was formed in 1995 when the VA Medical Centers in Fort Wayne and Marion, Indiana, were combined under one umbrella. This network expanded to include clinics across the state from Peru, to Goshen, and Muncie, Indiana (US, 2018, n.p.). The main campus of Fort Wayne "offers primary and secondary medical and surgical services," whereas the Marion campus "offers a full range of mental health, nursing home care, and extended care services" (US, 2018, n.p.). The services offered at the various clinics across the state consist of limited medical and psychiatric attention, with patients needing a greater level of care sent to one of the main campuses.

The Fort Wayne campus, in existence since 1950, is able to house 26 patients on campus who are in need of acute medical and/or surgical services. Primary care, specialty surgical care, and limited mental health services are also offered (US, 2018, n.p.). When a patient is in need of more extensive services, they are referred and sent to the Marion campus nearly two hours away to receive the variety of treatments not offered in Fort Wayne.

The Marion Campus was first established in 1889 as the National Home for Disabled Volunteer Soldiers. The primary focus of this campus is mental health treatment, and as such, they are able to house 75 acute psychiatric patients in addition to the 150 beds available for long-term nursing homecare. Besides the mental health services, this campus also offers the same medical and surgical specialty care as the Fort Wayne campus (US, 2018, n.p.).

At all locations, main campuses and satellite clinics, the same basic mental health services are offered. These include "mental health consultation, dual diagnosis, intensive case management, mental health clinic, PTSD clinic, smoking cessation, substance abuse treatment (outpatient), and vocational rehabilitation" (US, 2018, n.p.). Services offered exclusively on the Fort Wayne campus is inpatient substance abuse detoxification. The services offered exclusively at the Marion campus are much more extensive. In addition to both acute and chronic inpatient beds, this campus also offers compensated work and incentive therapies, but also psychogeriatric programs and inpatient substance abuse treatment (US, 2018, n.p.). Any veteran needing the more extensive mental health services offered by the VA, regardless of their location in Indiana, are sent to the Marion campus to receive treatment.

In 2004, the U.S. Department of Veterans Affairs announced its plan to close the Fort Wayne campus, but eventually reconsidered. Years later, in 2012, the infirmary was shut down for over a month due to "staffing shortages, lapses in clinical judgement and leadership failures" (Local, 2018, n.p.). Through the following year, the infirmary was gradually opened back up, with each phase opening up more beds and allowing for more intensive procedures and cares to be performed. Despite all these setbacks, the Fort Wayne campus has remained open and climbs higher in funding priority on the national list of projects to be funded and completed. The budget for fiscal year 2019 "ranks the construction of a 'West Tower' at the Fort Wayne VA Medical

Center as No. 8 on its list of 431 strategic capital investments" (VA, 2018, n.p.). This new tower would be 27,000 square-feet in a two story addition, the bottom floor would have a new emergency department, and the second floor would consist solely of patient rooms. Lastly, this funding would support a new facility where any equipment needing sterilized could be done in Fort Wayne rather than being sent to Marion, currently the only sterilization facility for the VA in Indiana.

The fate of the Fort Wayne Campus has been up in the air for over a decade now. Scandals have rocked the administration, questions have been raised about the quality of care, and the public and staff have wondered if the campus will stay open or not. The future looks brighter for the Fort Wayne campus, as Congress is approving increasing yearly budgets and projects to improve the grounds and buildings. It is hoped that with the new tower being built, a greater amount and acuity of services can be offered to veterans.

Solutions and Treatments

In order to effectively help any individual, the overall culture towards mental illness needs to be addressed. Before the views and attitudes towards those with mental illness, from both society at large and specifically within the military, all treatments will only temporarily address the issue, inevitably leading to another incidence or another individual being adversely affected by stigma. As such, the long-term goal, albeit an ambitious one, is to change the culture and views surrounding mental illness. More short-term treatments, such as continuing to implement the population-based care model in addition to various psychotherapies and medications, need to become more widespread in application and availability. The VA needs to continue to partner with agencies outside of its umbrella and approve costs for treatment from these partners. They also need to continue implementing their telehealth initiative and

establishing satellite clinics, which offer a limited number of services to communities previously having access to none. The tools already exist to combat this problem, but the issue lays in ineffectively reaching all the individuals needing services and the stigma surrounding the treatments.

Reducing Stigma

While reducing stigma is a large, general goal, and is the ultimate endpoint, the goal needs to be broken down in order to be achievable. To facilitate this, it is necessary to split stigma into two categories: reducing stigma from the public, and reducing stigma within the military. For the public, simply raising awareness and informing others about mental health, that there should not be a negative stereotype or view towards those with mental illness, has been counterproductive. Britt and Shortridge (2007) identify this strategy as "lead[ing] individuals to recall more negative information about persons with mental illness" (p. 160). More successful strategies include educating and providing factual information to society. This can take many forms such as pamphlets, commercials, and testimonials among others and has been met with some success. They found that, above all, providing "accurate information about the etiology and treatment" of these problems provided the greatest success for this avenue (Britt et al., p.160). In addition to providing information, setting up one-on-one sessions between a member of the public and an individual suffering from mental health issues has been shown to have a high rate of success (Britt et al., p.160). However, without a change in the smaller community that is the military, effective change in society regarding this issue cannot happen.

Within the military cultural context, having one-on-one contacts and providing factual information has had some success (Britt et al., p.160); however, the hierarchical and competitive nature of the military requires a different approach to combating this problem. Due to the strict

hierarchy everyone must adhere to, when superiors have negative views towards mental illness, not only does this limit the expression of the issue within their command but it also causes the view to influence and permeate the beliefs of those within their command. Because of this, a more targeted education campaign for non-commissioned (NCO) and commissioned officers (CO) has been shown to be successful on a unit and division level in reducing negative stigmas. A study conducted by Dondanville, Borah, Bottera, and Molino (2018) showed that this type of intervention, a one hour educational briefing, had a significant positive impact on the views of COs and NCOs towards mental health issues within their command. Following the briefing, over 80% said they would feel comfortable seeking treatment for PTSD if needed and saw almost a tripling of those saying they would be comfortable openly talking about mental health issues with those under their command compared to before the briefing (Borah et al., p. 22). In addition to these areas, there was also a marked increase in trusting mental health professionals as well as being able to identify signs and symptoms of PTSD in soldiers under their command. While this study was limited to one base in Texas, the implications from the study indicate it could be highly effective if implemented on a military wide basis.

Besides promoting the idea of COs and NCOs taking an active role in identifying and encouraging those with mental health issues to seek treatment, there are changes that need to take place at a policy level and in general within military culture in order to reduce the current stigmas. One major barrier soldiers face when deciding to seek treatment is the perceived or actual effect it could have on their career. Britt and Shortridge (2007) identify examples of soldiers losing their security clearances and ultimately their jobs after it became known they sought out mental health services because they can no longer conduct them without the clearance

(pg. 160). Security clearances and jobs should not be put into jeopardy for seeking mental health treatment.

Other changes to policy that need to be addressed include being able to seek mental health services while on duty or deployed as well as during the day. Often times the constraints placed on service members when they can seek treatment effectively makes the treatment impossible.

Outside of policy, another way the military can change is to allow visits to mental health professionals to remain anonymous. When using services within the military, the visit is recorded a soldier's personnel file, leading to an increased use of outside or private services, which is hampered by the time constraints and location of the soldiers (Britt et al., 2007, p. 159). Lastly, by simply acknowledging that these issues exist, are real, and seeking treatment is okay, leadership at the highest levels could start the change in culture from the top down.

Population-Based Care

On a different vein, a major shorter-term goal for combating the issue of mental health would be the implementation of a systematic approach towards treatment that streamlined care and reached a greater number of individuals. The most widely accepted and proposed system is the concept of population-based care. Charles Engel, professor in the department of psychology for the Uniformed Services University of the Health Sciences, in addition to his position at Walter Reed Army Medical Center, with Kenneth Hyams, Director of the Office of Public Health and Environmental Hazards for the Department of Veterans Affairs, explain how this model can be applied to the military to treat mental health issues. Besides increasing the number of individuals treated, this model also works by reducing stigma for the treatment. They illustrate the overall goal of this treatment model as to "achieve maximum efficiency and effectiveness

through an optimized mix of 'population-level' and 'individual-level' interventions" (Engel et al, 2006, p. 710). This approach uses an organized, step-up approach that begins with the routine primary care that over 90% of service members seek each year (Engel et al, 2006, p. 712) and can end up with intensive rehabilitation services if warranted. By beginning all services through the primary care offices, this helps reduce the stigma attached to the seeking mental health services as well as increases the number of soldiers that can be identified and treated for mental health issues.

The four step process that population-based care is modeled on begins with pre-clinical prevention. This process involves a wide variety of steps taken to prevent or mitigate damages from catastrophic events, usually from being in combat theatre, before the individual seeks out routine primary care. A current widely used strategy at this level is critical incident stress debriefing which involves working through the traumatic event as soon as possible after the occurrence. Engel (2006) points out that these sessions often lead to further issues through the medicalization of the experience and encourages the individual to feel symptoms (p. 711). Another widely used approach, also found to be ineffective, includes mass screenings of individuals to look for signs and symptoms of a wide variety of both physical and mental health issues. This process has been found to have a large number of false negatives and positives as it relies mainly on self-reporting in addition to increasing the stigma associated with the problems. Instead, Engel (2006) proposes to move the screening for these issues into the second step, routine primary care, as the vast majority of individuals seek out primary care sometime throughout the year. This would leave the pre-clinical prevention being primarily a teaching step, where the symptoms and what to look for are taught, services and resources are made known, and coping strategies are gone over for when a traumatic event does occur.

The focus of the second step of population-based care is tracking and monitoring suspected post-war symptoms such as PTSD among other physical and mental ailments. This step involves education of doctors, nurses, and health care professionals who deal with a large population of veterans and active duty soldiers on the common diseases and symptoms that they face. Identifying these individuals is key as it allows for a multitude of positive outcomes for the patient. First, it allows the patient to collaborate with the doctor about the goals of treatment as well as participate in decision making for care. Second, it lets the care be gradually intensified, which allows the individual to become more comfortable and have time to accept what they are being treated for. Lastly, this approach reduces the stigma attached to mental illness as a medical doctor is initiating the mental health treatment if it is warranted rather than a psychiatrist or psychologist (Engel et al., 2006, p. 712). Because the culture of the military commonly accepts physical limitations and disabilities, a mental issue can be rationalized to be more acceptable if it comes from a doctor who is more accepted for other medical issues. From this step of the model, necessary care from the next step is dictated by persistence of symptoms. If the individual adheres to the treatment plan, and if there are comorbidities (other illnesses and/or issues) present.

After three to six months of symptom persistence, it becomes necessary to involve other physicians and specialties to supplement the primary care provider. Engel (2006) notes that this step not only provides an increased level of care but also greater opportunity to disclose and discuss concerns about exposure to possible toxic substances and greater access to services commonly stigmatized throughout the military (p. 712). Commonly included elements on the care team include physical or occupational therapies, psychological services, specialist interventions such as neurology or orthopedics, and patient education. There are numerous

benefits from this step in the model for the patient. It allows for minimization of stigma as all care is initiated through the primary care provider. This step also provides greater safety for the patient as one doctor is heading the case and doing the consulting with others before that single doctor makes decisions regarding care, limiting the exposure to harmful tests or wasted time through repeated exams. The last majorly cited benefit for this step in the approach is the ability for follow-up and tracking of the patient (Engel et al., 2006, p. 712). Because there is a single point that coordinates all the care, the primary care physician has the ability to more closely monitor the patient's progress whether the issue is medical or psychological in nature. Engel (2006) also points out that through this step, compliance with psychotherapies has been rising, especially when the services are offered in the same office as the primary care physician (p. 713). It can be concluded that this step specifically plays an instrumental role in reducing the self-stigma and perceived social stigma an individual being treated for mental health issues experiences.

The last step in the population-based care model is intensive rehabilitation. This can take on a variety of forms, inpatient and outpatient, as well as varied lengths of stay and services provided. The most common forms for war-related symptoms and diseases Engel (2006) specifies are "3-4 week inpatient" or "intensive… 10-15 week programme of weekly or biweekly" sessions (p. 713). Other services included in these broad programs include psychosocial treatments, such as cognitive behavioral therapy or group therapy sessions, in addition to exercise programs and social services that work with reintegration into society. This final step is the most intensive and personalized, but it has shown to be effective in treating both mental and physical diseases. This personalization and success is made possible by the step-up approach and single person coordinating all elements of care. Even though the systematic

population-based care is simply a model to follow, it has been shown to be effective in incorporating a variety of treatment modalities, increase treatment effectiveness, and increase patient satisfaction with care.

Psychotherapies

The most focused on and widely used treatment modality, mentioned above, is psychotherapy. The main subcategory of this therapy is cognitive behavior therapy, which can further be broken down into subcategories of exposure and cognitive therapy, as well as a much newer subcategory called eye movement desensitization and reprocessing, both of which have the two same main goals in mind. First, normalizing of the stress response is the primary goal of all psychotherapeutic approaches (Garske, 2011, p. 33). This essentially means that the individual is trained to cope with their response to a stressful situation in a way that is healthy as opposed to a maladaptive or harmful manner. The second goal of psychotherapies goes into meeting the first because it stipulates that these therapies should reduce, or eliminate if possible, the maladaptive psychological processes that can lead to an inappropriate stress response (Garske, 2011, p. 33). Through therapy, it is hoped that an individual learns to positively cope with stress and can lead a normal life dealing with daily stressors.

Cognitive behavioral therapy (CBT) can take the form of either exposure and cognitive. Exposure therapy involves repeated exposure to the traumatic event or stimuli eliciting the same responses and having the patient describe each minute detail of the situation over and over again. Prolonged exposure, therapy over an extended period of time, is the considered the go-to treatment for PTSD. Gregory Garske (2011), professor of psychology and graduate coordinator for the mental health programs at Bowling Green State University, points out that prolonged exposure "significantly reduces PTSD symptoms" and is included in the guidelines for treating

returning OIF/OEF veterans (p. 34). This technique relies on the emotional processing theory in that by repeatedly exposing individuals to a frightening or traumatic situation, they are able to reprogram the feelings they associate with the event, thereby alleviating the PTSD symptoms. Garske (2011) also points out that exposure therapy has "more empirical evidence for its efficacy than any other treatment," which is why it is held as the first-line of treatment (p. 34). Some issues that have arisen for this particular therapy include the patient dropping out of treatment, comorbidities contraindicating CBT, and the limited training and strained uses of VA practitioners that have limited its use within the system.

The cognitive subcategory of CBT focuses on using talk therapy to change the negative and/or wrong perceptions the veteran has about the world around. Examples of these thoughts include "perceiving the world as dangers, seeing oneself as powerless… and feeling guilty for outcomes" (Garske, 2011, p. 34). The goal is to restructure these beliefs, which allows the patient to overcome the feelings and thoughts they have. The two different approaches to this treatment include present-focused, the more widely used approach, and trauma-focused. Present-focused involves the use of a diary or log to monitor thoughts and emotions throughout the day or week. The therapist then goes through this with the patient to help identify patterns in thinking and dispute or correct the incorrect thoughts. Trauma-focused would be talking through the particular traumatic event and finding out what meaning it has for the patient. This application usually results in fewer sessions, is more effective the closer to the trauma it occurs, and often results in relapse and recurrence of PTSD symptoms (Garske, 2011, p. 34). CBT is the most common form of psychotherapy and has been found to have the greatest amount of success for treatment, so it is considered an essential part of any treatment plan.

Another form of psychotherapy rapidly gaining use, and even thought to possibly overtake CBT in effectiveness, is eye movement desensitization and reprocessing (EMDR).This therapy involves the patient imagining the traumatic experience and the negative emotions associated with it, while focusing on the rapid movement of the therapist's finger or quickly changing images. It is thought that the rapid eye movement help in reconditioning the patient to not associate particular feelings with an event as the rapid movement interrupts the thought processes. This therapy is focused on using the distraction and rapid eye movements to recondition the mind and the associations it creates (Garske, 2011, p. 34). This therapy is relatively new and remains controversial among some therapists as an accepted form of treatment; however, several trials have shown the effectiveness of this treatment and it is growing in use. At this time, CBT still remains the primary psychotherapy employed in the treatment of PTSD.

Medications

Before the advent of CBTs, medication was the primary form of treatment for PTSD symptoms. It was common to prescribe an antianxiety, antipsychotic, or benzodiazepine, which resulted in covering up the symptoms rather than treating the underlying cause. While some of these medicines are still prescribed currently, the type of medicine found to be most effective in treatment is a selective serotonin reuptake inhibitor (SSRI). The Food and Drug Administration has approved two SSRIs for use in PTSD patients, sertraline and paroxetine. These have been shown to "improve quality of life… improve functional status, decrease symptom severity, and reduce vulnerability to stress" (Garske, 2011, 33). Even though SSRIs have shown remarkable results in some patients, in others, it has not been effective; therefore, psychotherapy is always included in treatment when medications are prescribed. It is thought that medications can help

with symptom control and management, but the psychotherapy will help to treat the underlying causes.

Telemedicine

An area being explored to help enhance the delivery of psychotherapy is providers using telemedicine to increase the number of people clinicians can reach. The VA has recognized using technology, such as videoconferencing, can help increase the "equal and timely access to mental health care" (Keane, 2011, p. 504), but concerns remain with the security side of things. Many have raised concerns about the viability of ensuring secure connections in order to comply with confidentiality regulations as well as the actual effectiveness of the therapy compared to in-person therapy. Because this technology is somewhat new, the VA has been reluctant to widely implement this citing lack of funding and lack of empirical research showing the equality compared to in-person delivery of psychotherapy (Keane, 2011, 504). However, telemedicine has been shown to decrease the stigma perceived by veterans about seeking mental health treatment because it allows them to receive the treatment in more privacy than going to an actual office for the treatment. Even though the VA has been hesitant to fully commit to telemedicine, it has developed and released a smartphone app, PTSD Coach, which has been used in conjunction with traditional psychotherapy, allowing the patient and clinician to track in real time symptoms and stay connected outside of scheduled appointments (Keane, 2011, 504). The VA is exploring the idea of telemedicine, but until more research is done, it will not implement and commit to an idea that has promise to increase the number of veterans treated and reduce costs for the treatment.

Conclusion

Progress is being made to positively impact the mental health issue from both the treatment side of the issue and the culture side as well. In both civilian society and the military, conversations about mental health issues have become less taboo and more accepted. Awareness campaigns and small scale interventions such as the one targeting NCOs to inform them about PTSD contribute to the mental health conversation. Also adding to the conversation is an increased number of soldiers being directly or indirectly affected by mental illness. The military has made it officially against policy to punish someone, or allow seeking of treatment, to adversely affect the individual's career. Whether that policy is enforced or followed remains to be seen, but steps are being taken in the right direction.

The VA's strategic goal to focus on treating mental health issues was a good first step in the treatment process. To further achieve this goal, the VA needs to implement the population-based patient care model across the country and stress the importance of referrals and open communication about mental health issues with patients to the primary care physicians seeing the veterans. The model has proven itself to reduce stigma and costs, as well as to increase compliance with the treatment regimen by the patient. In addition to this model, the VA needs to rollout a much wider implementation of telemedicine. Satellite locations already exist and smaller clinics to support the medical care the bigger hospitals provide, so the VA can just integrate the telemedicine aspect into these sites as well. This would keep overall costs down in implementing widespread mental health care as well as reinforce the reduced stigma by going through the primary care physician.

Specifically in Indiana, the use of telemedicine could work very well. In addition to the three main hospital campuses located in Indianapolis, Marion, and Fort Wayne, the VA has ten other clinics located throughout the state. This would allow patients to remain closer to home

while receiving care, instead of being sent to Marion for treatment. While this solution does not necessarily solve the inpatient psychiatric beds being located only in Marion, it helps treat patients before they get to the point of needing inpatient care.

This project highlights the problem of mental health care for military veterans, but it also shows the progress being made to correct the issue. Many different effective treatment modalities were explored and possible solutions to the stigmatization from the public and within the military were presented. This project provides a good starting point for further research. The information within applies all over the United States. No matter the location, the basic theories, problems, and treatments remain the same. Research can be conducted on a specific area, using what is contained within this paper as the basis. The information in this thesis also provides a source of information about the issue in general and explores all the treatment options as well as be invaluable information to a practitioner, from a patient care assistant up to a skilled surgeon, who has little experience dealing with the veteran population. And lastly, this content can inform someone suffering from mental illness about their treatment options and show them they are not alone in dealing with their issues. Strides have been made in combating the mental health epidemic plaguing the military, and this research project, through simply educating about the issue and exploring other possible avenues to help veterans, can further this fight.

References

Borah, E., Bottera, A., Dondanville, K., & Molino, A. (2018). Reducing Stigma in PTSD Treatment Seeking among Service Members: Pilot Intervention for Military Leaders. *Best Practices in Mental Health, 14*(1), 15-25.

Britt, T. W., Castro, C. A., & Greene-Shortridge, T. M. (2007). The Stigma of Mental Health Problems in the Military. *Military Medicine, 172*(2), 157-160. https://doi.org/10.7205/MILMED.172.2.157

Engel, C., Hyams, K., Scott, K. (2006). Managing future Gulf War Syndromes: international lessons and new models of care. *Philosophical Transactions of the Royal Society (361)*, 707-720. Doi: 10.1098/rtsb.2006.1829

Francisco, B. (27 November 2018). Local VA hospital shows off updates. *The Journal Gazette*.

Francisco, B. (22 February 2018). VA makes local addition priority. *The Journal Gazette.*

Garske, G. (2011). Military-related PTSD: A Focus on the Symptomatology and Treatment Approaches. *Journal of Rehabilitation 77*(4), 31-36.

Keane, T., Marx, B., Sloan, D. (2011). Reducing the Burden of Mental Illness in Military Veterans: Commentary on Kazdin and Blase. *Perspectives on Psychological Science, 6*(5), 503-506. doi:10.1177/1745691611416995

Marmar, C. (2009). Mental Health Impact of Afghanistan and Iraq Deployment: Meeting the Challenge of a New Generation of Veterans. *Depression and Anxiety, 26*, 493-497.

Oak, S., & Pols, H. (2007). WAR & Military Mental Health The US Psychiatric Response in the 20th Century. *American Journal of Public Health, 97*(12), 2132-2142. doi: 10.2105/AJPH.2006.090910

Veterans. (2019). National Council for Behavioral Health. Retrieved from https://www.thenationalcouncil.org/topics/veterans/

Veterans & Active Duty. (2019). National Alliance on Mental Illness. Retrieved from https://www.nami.org/Find-Support/Veterans-and-Active-Duty

US Department of Veterans Affairs, & Veterans Health Administration. (2018, April 26). VA Northern Indiana Health Care System. Retrieved from https://www.northernindiana.va.gov/about/index.asp